Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH FORT WORTH
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-11-0685-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid correctly according to the Hospital Facility Fee Guideline for inpatient claims. Pursuant to Rule 134.404, reimbursement, 'regardless of billed charges' (quoted from section (e)){sic}, is to be paid at 143% of the Medicare rate unless implants were requested to be carved out of the reimbursement amount at billing. No such request was made; therefore, the allowable would be 143% of the DRG rate under Medicare pursuant to section (f) of the rule." "The allowable is $12,157.84 X. {sic} 143% of this amount is $17,385.71. After their payment of $16,896.72 we still have a balance due of $488.99 due."

Amount in Dispute: $488.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent Dallas National respectfully requests the DWC dismiss this MDR because it was not filed timely. As the documentation provided by the Requesting Party clearly establishes, the disputed services are from October 23, 2009 – November 2, 2009. This dispute was filed on September 7, 2011 which is almost two (2) years from the dates of the disputed services."

Response Submitted by: Lewis & Backhaus, PC, The Crossings, 5501 LBJ Freeway, Suite 800, Dallas, Texas 75240

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2009 Through November 2, 2009	Inpatient Hospital Surgical Services	$488.99	$488.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the rules for medical bill submission by the health care provider.
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
4. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
5. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 23, 2010
   - W1 –Workers Compensation State Fee Schedule Adjustment.
   - Z710 –The charge for this procedure exceeds the fee schedule allowance.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)(1)?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307(c)(1)?
3. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
4. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
5. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
6. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The dates of

service in dispute are October 23, 2009 through November 2, 2009. The request for medical dispute resolution was date stamped received in the Medical Fee Dispute Resolution (MFDR) section on October 22, 2010.

2. The Division finds that pursuant to 28 Texas Administrative Code §133.307(c)(1), this dispute was filed timely with the Division and, therefore will be reviewed in accordance with applicable Division rules and fee guidelines.
3. No documentation was found to support a contractual agreement between the parties to this dispute. Therefore, the Division concludes that the disputed services are not included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.
4. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
5. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
6. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 871 is $12,157.84.

   This amount multiplied by 143% is $17,385.71.

   The total maximum allowable reimbursement (MAR) is $17,395.71.

   This amount less the amount previously paid by the respondent of $16,896.72 leaves an amount due to the requestor of $488.99.

   The Division concludes that the requestor is entitled to $488.99 additional reimbursement.

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Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $488.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $488.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 23, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.